

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements										
• Reduction Mammo-plasty	<p>Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953</p> <p>Phone: For clients with last names beginning with A - L, call: (406) 444-3993 In/out-of-state</p> <p>For clients with last names beginning with M - Z, call: (406) 444-0190 In/out-of-state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none">Both the Referring physician and the surgeon must submit documentation.Back pain must have been documented and present for at least six months, and causes other than weight of breasts must have been excluded.• Indications for female client:Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.Female client 16 years or older with a body weight less than 1.2 times the ideal weight.There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions:<ul style="list-style-type: none">Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercisesParesthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back. <p>Documentation in the client’s record must indicate and support the following:</p> <ul style="list-style-type: none">History of the client’s symptoms related to large, pendulous breasts.The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).Guidelines for the anticipated weight of breast tissue removed from each breast related to the client’s height (which must be documented): <table><tr><th>Height</th><th>Weight of tissue per breast</th></tr><tr><td>less than 5 feet</td><td>250 grams</td></tr><tr><td>5 feet to 5 feet, 2 inches</td><td>350 grams</td></tr><tr><td>5 feet, 2 inches to 5 feet, 4 inches</td><td>450 grams</td></tr><tr><td>greater than 5 feet, 4 inches</td><td>500 grams</td></tr></table> <ul style="list-style-type: none">Pre-operative photographs of the pectoral girdle showing changes related to macromastia.Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.• Indications for male client:If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs	Height	Weight of tissue per breast	less than 5 feet	250 grams	5 feet to 5 feet, 2 inches	350 grams	5 feet, 2 inches to 5 feet, 4 inches	450 grams	greater than 5 feet, 4 inches	500 grams
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PA Criteria for Medicaid Prescription Drugs

Drug	Criteria
Actiq Lozenges (fentanyl)	<ul style="list-style-type: none"> No history of MAOI use within the last 30 days Initial doses greater than 200mcg will not be approved. Initial therapy will be defined as patients not having Actiq therapy in the last 30 days Non-cancer diagnoses will not be approved Greater usage than 4 units of any strength per day Authorization for existing usage in pain of non-cancer origin will be granted on an individual basis in consultation with the prescriber to prevent withdrawal syndromes.
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in patients who have experienced a transient ischemic attack or previous ischemic stroke and who have had a recurrent stroke while on aspirin or have failed plavix.
Antiemetics Kytril Tablets and oral solution. PA required for quantities greater than 10 units in a 30-day period. Zofran Tablets and oral solution. PA required for quantities greater than 15 units in a 30-day period. Anzemet Tablets PA required for quantities greater than 5 units in a 30-day period.	For prescription exceeding monthly quantity limits for the prevention of nausea and vomiting associated with chemotherapy/radiation therapy, or for nausea and vomiting associated with pregnancy when traditional therapies have failed. Quantity limits for these and other indications will be considered on a case by case basis.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.
Avinza (Morphine sulfate extended-release capsules) PA required for quantities greater than once daily.	Requests exceeding these quantity limits will be considered on an individual basis.

PA Criteria for Medicaid Prescription Drugs (continued)	
Drug	Criteria
COX-2 Inhibitors Celebrex (celecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: <ul style="list-style-type: none"> • History of previous GI bleeding within the last 5 years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD • For clients 65 years of age • Currently on anticoagulant therapy
Dipyridamole	As adjunct to warfarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacement.
Disease-Modifying Anti-Rheumatic Drugs (DMARD) Arava (leflunomide) Enbrel (etanercept) Humira (adalimumab) Kineret (anakinra) Remicade (infliximab)	<ul style="list-style-type: none"> • Diagnosis of rheumatoid arthritis • Rheumatology consult with date and copy of consult included • Kineret may be used alone or in combination with DMARD's other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel) <ul style="list-style-type: none"> • Enbrel whether alone or in combination with methotrexate. • Enbrel or Remicade may be approved with Arava on an individual basis. • Remicade when used in combination with methotrexate may be approved for first-line treatment in patients with moderately to severely active rheumatoid arthritis as evidenced by: <ul style="list-style-type: none"> • > 10 swollen joints • \geq 12 tender joints • Elevated serum rheumatoid factor levels or erosions on baseline x-rays • Remicade therapy will only be approved following a negative TB test • Enbrel also covered for psoriasis when accompanied by a prescription from a dermatologist.
Remicade (infliximab)	Also covered for the following diagnoses: <ul style="list-style-type: none"> • Moderately to severely active Crohn's disease for patients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Erectile Dysfunction Viagra (sildenafil) Cialis (tadalafil) Levitra (vardenafil) Quantity limited to one (1) tablet per month	<ul style="list-style-type: none"> • Diagnosis of erectile dysfunction. • Males only, 18 years of age or older. • No concomitant organic nitrate therapy.

PA Criteria for Medicaid Prescription Drugs (continued)	
Drug	Criteria
<p>Gastro-intestinal drugs</p> <p>Includes H-2 antagonists, proton pump inhibitors, and Cytotec</p> <p>Prior authorization is required only for concomitant usage of an H2-antagonist and a proton pump inhibitor. This PA requirement is designed to avoid therapeutic duplications.</p>	<p>Diagnosis of:</p> <ul style="list-style-type: none"> • Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas) • Symptomatic gastroesophageal reflux (not responding or failure of maintenance therapy) • Symptomatic relapses (duodenal or gastric ulcer) on maintenance therapy • Barretts esophagus • GERD <p>Other conditions considered on an individual basis.</p>
Growth hormones	<p>Diagnosis of:</p> <ul style="list-style-type: none"> • Growth hormone deficiency in children and adults • Growth retardation of chronic renal insufficiency • Turner's Syndrome • AIDS-related wasting <p>Children and adolescents must meet the following criteria:</p> <ul style="list-style-type: none"> • Standard deviation of 2.0 or more below mean height for chronological age • No expanding intracranial lesion or tumor diagnosed by MRI • Growth rate below five centimeters per year • Bone age 14-15 years or less in females and 15-16 years or less in males • Epiphyses open <p>Growth hormone deficiency in children: Failure of any two stimuli tests to raise the serum growth hormone level above 10 nanograms/milliliter.</p> <p>Growth retardation of chronic renal insufficiency: Irreversible renal insufficiency with a creatinine clearance <75 ml/min per 1.73m² but pre-renal transplant.</p> <p>Turner's Syndrome: Chromosomal abnormality showing Turner's syndrome.</p> <p>Growth hormone deficiency in adults:</p> <ul style="list-style-type: none"> • Adult Onset: Patients have somatotropin deficiency syndrome (SDS) either alone or with multiple hormone deficiencies, (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. • Childhood Onset: Patients who had growth hormone deficient during childhood and now have somatotropin deficiency syndrome (SDS).

PA Criteria for Medicaid Prescription Drugs (continued)	
Drug	Criteria
Thalomid (thalomide)	Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). Considered for other diagnoses on individual basis.
Toradol (ketorolac) For quantity greater than a 5-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Tretinoin PA required for patients 26 years and older.	Diagnose of: <ul style="list-style-type: none"> • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Xanax XR (alprazolam extended-release tablets)	<ul style="list-style-type: none"> • Xanax XR tablets may be covered for patients who have not responded to adequate trials of at least two generic long-acting benzodiazepines, one of which is generic alprazolam. • Coverage of Xanax XR will be allowed for once daily dosing only.
Zoloft 25 mg & 50 mg (sertraline)	Authorized for patients requiring dosages where tab splitting would be inappropriate (i.e., 75 mg, 125 mg).
Zyvox (linezolid)	Adult patients with vancomycin-resistant enterococcus.

PA Criteria for MHSP Prescription Drugs (continued)	
Drug	Criteria
buspirone (Buspar)	<ul style="list-style-type: none"> • Augmentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least two multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	<ul style="list-style-type: none"> • Diagnosis of bi-polar disorder.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) liothyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg & 50 mg)	Authorized for patients requiring dosages where tablet splitting would be inappropriate (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.